LEGISLATIVE SERVICES AGENCY
OFFICE OF FISCAL AND MANAGEMENT ANALYSIS

301 State House
(317) 232-9855

FISCAL IMPACT STATEMENT

LS 6682 **NOTE PREPARED:** Feb 1, 2003
BILL NUMBER: HB 1688 **BILL AMENDED:**

SUBJECT: Prescription Drug Program.

FIRST AUTHOR: Rep. Kersey **BILL STATUS:** As Introduced
FIRST SPONSOR:

FUNDS AFFECTED: X **GENERAL** **IMPACT:** State
X **DEDICATED**
X **FEDERAL**

Summary of Legislation: This bill authorizes the Office of Medicaid Policy and Planning (OMPP), in consultation with the Drug Utilization Review Board, to develop and implement a preferred drug formulary. The bill sets out parameters of the preferred drug formulary. It establishes the Rx Program to provide discounted prescription drug prices to Indiana residents who are: (1) uninsured; (2) underinsured; (3) Medicare recipients; and (4) covered under insured or self-funded employee welfare benefit plans that provide prescription drug benefits.

The bill allows a drug manufacturer or labeler that sells prescription drugs to voluntarily enter into a rebate agreement with the state Department of Health that requires rebate payments to be made to the state for the Rx Program. It authorizes the Department to negotiate the amount of the rebate and audit a manufacturer or labeler to assure compliance.

The bill also requires a retail pharmacy to sell the drugs covered by the Rx Program to participants in the Rx Program at the discounted price. The bill establishes: (1) a formula for the state to use in calculating discount prices for drugs covered by the rebate agreement; (2) a procedure for resolving rebate amount discrepancies; and (3) the Rx Dedicated Fund, consisting of revenue from manufacturers and labelers who pay rebates and appropriations to the Fund.

Effective Date: July 1, 2003.

Explanation of State Expenditures: *Preferred Drug Formulary* - The bill allows the Office of Medicaid Policy and Planning (OMPP) to establish a preferred drug formulary. The formulary would be similar to the Preferred Drug List (PDL) currently being implemented with an additional factor of the negotiated rebate for a drug as a determining factor in the drug's placement on the list. The bill also requires OMPP to apply for a waiver to negotiate supplemental drug rebates with manufacturers and drug labelers.

The bill defines a formula and a process for OMPP to use in establishing the rebates. These rebates would be in lieu of the existing federal rebates and are required to be more favorable to the state. Medicaid reported total drug rebate payments of $138.3 M for FY 2002. OMPP has not estimated costs or drug savings associated with implementing the formulary or the expanded rebate program; any associated administrative program costs would be reimbursed by the federal government at 50%. Savings associated with expanded rebates would be distributed to the program payers in the same percentages paid for the original claims; the state would receive 38% and the federal government would get 62% of any rebated cost.

Rx Program - This bill requires the Department of Health to administer the Rx Program, which allows qualifying individuals to obtain prescription drugs at discounted prices that are based on the preferred drug formulary. The Department has estimated that 147 new staff positions would be needed to implement this new program at a cost of $7.3 M the first year and $7 M in the second year. These estimates do not include the costs associated with a pharmacy benefits manager. In order to operate the Rx Program as described, the Department would need to have the infrastructure of the program administration in place upon enrollment of the first beneficiaries. (The bill requires retail pharmacies to be reimbursed within two weeks of the claim.) Rebate revenues are required on a quarterly basis. The necessary cash flow for program implementation would most likely need to be funded by the state General Fund.

The Maine Department of Human Services had implemented a discount prescription program for its low income residents in 2001. At a cost of approximately $2 M, Maine integrated its discount prescription program with the existing Medicaid prescription program structure within its department. The discount program piggy backs with the Medicaid system by utilizing the same claims processing system, point-of-sale system, discount cards, eligibility determination process, and administering department. According to the Department's web site, more than 200,000 of Maine's residents are eligible for the program. Maine's discount prescription program has been suspended due to legal action. The state of Wyoming also set up its discount prescription program utilizing its existing Medicaid structure.

The Kaiser Family Foundation reported that in 1996, 23% of the non-Medicare population and 31% of Medicare beneficiaries had no prescription drug coverage. Most of the non-elderly Americans without drug coverage were reported to have no health insurance at all. (The data reported is prior to the implementation of the CHIP program in Indiana.) Seniors lack drug coverage because Medicare does not cover outpatient prescription drugs and they do not have private insurance. Applying these percentages of individuals with no prescription drug coverage to Indiana population estimates for 1998, approximately 1.4 million Hoosiers (1,179,738 non-Medicare and 227,792 Medicare beneficiaries) would qualify for the Rx Program as individuals lacking prescription drug insurance. The bill does not define the term underinsured; no information is available to estimate the size of the underinsured population.

The bill also requires the Department to reimburse retail pharmacies for the discounted prices they provide to qualified Rx Program participants and pay a dispensing fee that is at least the greater of the Medicaid dispensing fee (currently $4.90) or $3, or some higher amount as determined by the Department for each prescription dispensed to the qualifying participants. The Department may not impose any transaction fees on pharmacies that submit claims for reimbursement under the Rx Program. The Department may also audit any manufacturer or labeler who has entered into a rebate agreement to ensure it has complied with the agreed upon price. If the manufacturer or labeler is found to not be in compliance, the Department may require a refund and hire counsel to collect any outstanding amounts and fees. Any money collected from such an audit is to be deposited in the Rx Dedicated Fund (see *Explanation of State Revenues* below).

Explanation of State Revenues: In FY 2002, the Medicaid Program reported 738,633 recipients and paid

legend drug claims of $650.7 M. The total average annual drug expenditure was approximately $881 for the Medicaid-enrolled population. For the same fiscal year, Medicaid reported total drug rebate payments of $138.3 M. Rebates are estimated to be 21% of the total outpatient pharmacy claims, or $185 per recipient. If it is assumed that Medicaid outpatient pharmacy experience is applicable to the uninsured and under-insured population, the Rx Program rebates might produce annual revenue of $260.4 M. After deducting annual administrative expenses, this would potentially allow $253.1 M, or $179.81 per recipient, to be distributed as drug discounts and dispensing fees. Due to the seriously disabled population covered within Medicaid, this estimate should probably be regarded as the maximum of the range of rebates that could be achieved within the Rx Program. Inclusion of the general population, many of whom would have few or no claims would be expected to dilute the amount of cash available for discounts to be distributed. The addition of an "underinsured" group would be expected to increase this effect.

Rx Dedicated Fund - The bill also establishes a dedicated fund into which rebates from manufacturers and labelers will be deposited, as well as appropriations and allocations. The Fund is to be used for reimbursing retail pharmacies for the discounted prices they offer to Rx Program participants. The Department is to administer the Fund, and expenses from doing so (such as contracted services, computer costs, retail pharmacy dispensing fees, and other reasonable Rx Program costs) are to be paid from the Fund. Money in the Fund at the end of the state fiscal year does not revert to the state General Fund.

Explanation of Local Expenditures:

Explanation of Local Revenues:

State Agencies Affected: Department of Health; Family and Social Services Administration, Office of Medicaid Policy and Planning.

Local Agencies Affected:

Information Sources: "*Demographic Trend Report, Division of Family and Children Selected Assistance Programs for State Fiscal Year 2000*"; The Henry J. Kaiser Family Foundation "*Prescription Drug Trends*" Fact Sheet #3057 at the Kaiser Foundation web site at www.kff.org; Zach Cattell, Legislative Liaison for the State Department of Health, (317) 233-2170; Jude Walsh, Maine Department of Human Services, (207) 287-1815 www.state.me.us/bms/hmpwebsite; Susan Malm, Wyoming Medicaid Pharmacy Program, (307) 777-5548; U.S. Census population estimates at www.census.org/statab/USA98/18/000.txt.

Fiscal Analyst: Kathy Norris, 317-234-1360